

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 2, 2003

RE: MDR Tracking #: M2-03-1554-01-ss
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has ADL certification. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant has a history of chronic back and leg pain allegedly related to a compensable injury of ___.

Requested Service(s)

Anterior lumbar interbody fusion at L3-4, L4-5 and L5-S1 and posterior decompression at L4-5 and L5-S1.

Decision

I agree with the insurance carrier that requested intervention is not medically necessary.

Rationale/Basis for Decision

According to a clinical note dated 04/18/03, the claimant has pain that radiates into the left groin and the left knee. Discogram performed on 07/24/02 does not document reproduction of concordant pain. To the contrary the report expressly documents that there was no extensions in lower extremities with injection at L4-5 or L5-S1. Mid to lower back pain only was reproduced at L3-4. Left lower back pain was reproduced at L4-5. Left sided low back pain was reproduced

at L5-S1. There is no documentation of concordant pain reproduced with discogram. The documentation provided a three level fusion which is not reasonable or medically necessary and further clinical evaluation is strongly recommended.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.